Your Anthem Benefits

Anthem

State of Indiana Benefits Comparison Summary of Benefits for 2006

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY)		
	HEALTH SAVINGS ACCOUNT	TRADITIONAL PLAN	TRADITIONAL PLAN II
Deductible (Single/Family) *(Applies only to percent (%) copayments)* *Deductibles are co-mingled Network and Non-network)*	$ 2,500 single Network/Non-network $ 5,000 family Network/Non-network Family Coverage requires the family deductible to be met before coinsurance applies. The single deductible DOES NOT apply to family coverage	$500 single Network/Non-network $1,000 family Network/Non-network	$0 single Network/Non-network $0 family Network/Non-network
Out of Pocket Maximum (Single/Family) Out of pockets are co-mingled Network and Non-network	$4.000 per enrollee $8,000 per family Includes the deductible Rx copay(s) do accrue to out of pocket	$1,500 per enrollee $3,400 per family Includes the deductible Rx copay(s) do not accrue to out of pocket	$2,000 per enrollee $4,000 per family Includes the deductible Rx copay(s) do not accrue to out of pocket
	The out of pocket maximum limit accrues on a calendar year basis. After the out-of-pocket limit has been met, benefits are paid at 100% of covered charges for the remainder of that calendar year.		
Professional Office Services Including allergy – testing and treatment – serum and injections	20% Network/40% Non-network per visit	20% Network/40% Non-network per visit	$20 Network/40% Non-network per visit
Preventative Care Services	20% Network/40% Non-network Not subject to deductible	20% Network/40% Non-network Subject to deductible	$20 Office Visit Co pay Network/40% Non-network
	Services include: immunizations for eligible dependents, annual physicals for employees and their eligible covered dependents, flu shots, annual pap smears and diagnostic services performed with the annual physical. This benefit does not include inpatient services or surgical procedures.		
Maternity Services	20% Network/40% Non-network	20% Network/40% Non-network	$500 Network/40% Non-network
Inpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	$500 Network/40% Non-network
Outpatient Facility Services	20% Network/40% Non-network	20% Network/40% Non-network	$250 Network/40% Non-network
Professional Inpatient/Outpatient Services	20% Network/40% Non-network	20% Network/40% Non-network	Covered in full Network/40% Non-network
Emergency and Urgent Care: • Emergency Care in ER Room • Urgent Care Facility	20% Network/20% Non-network	20% Network/20% Non-network	$75 Network or Non-network $35 Network or Non-network
Ambulance	20% Network/20% Non-network	20% Network/20% Non-network	$50 Network or Non-network
Radiation/Inhalation Therapy	20% Network/40% Non-network	20% Network/40% Non-network	$20 Office Visit Copay Network/40% Non-network
Medical Supplies, Equipment and Appliances	20% Network/40% Non-network		
Outpatient Therapy Services (Combined Network and Non-network limits apply) Limits apply to: • Physical therapy: 25 visits • Occupational therapy: 25 visits • Manipulation therapy: 12 visits • Speech therapy: 25 visits	20% Network/40% Non-network	20% Network/40% Non-network	$20 Office Visit Copay Network/40% Non-network
Mammogram	20% Network/40% Non-network Not subject to deductible	Covered In Full Network/ 40% Non-network Subject to deductible	$20 Office Visit Copay Network/40% Non-network Subject to deductible
	Includes 1 per person, per calendar year. Additional mammography services and ultrasounds are covered as determined medically necessary by your physician.		
Routine Prostate Antigen Tests (PSA)	20% Network/40% Non-network Not subject to deductible	Covered In Full Network/ 40% Non-network Subject to deductible	$20 Office Visit Copay Network/40% Non-network Subject to deductible
	Includes 1 per person, per calendar year		

COVERED BENEFITS	NETWORK/NON-NETWORK (MEMBER'S RESPONSIBILITY) HEALTH SAVINGS ACCOUNT	TRADITIONAL PLAN	TRADITIONAL PLAN II
Colorectal Cancer Exam/Laboratory Testing	20% Network/40% Non- network Not subject to deductible	20% Network/40% Non-Network Subject to deductible	$20 Office Visit Copay Network/40% Non-network Subject to deductible
Diabetes Self Management Training	20% Network/40% Non-network	20% Network/40% Non-Network	$20 Office Visit Copay Network/40% Non-network
Diagnostic Services (i.e. lab, x-ray, MRI)	20% Network/40% Non-network	20% Network/40% Non-Network	Covered in Full Network/40% Non-network
Temporomandibular Joint (TMJ) Services • Outpatient Facility • Provider Individual • TMJ Surgery • TMJ Other Services	 20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network	 20% Network/40% Non-network 20% Network/40% Non-network 20% Network/40% Non-network	 $250 Copay Network/40% Non-network $20 Office Visit Copay Network/40% Non-network Covered in Full Network/40% Non-network
	$2,500 lifetime maximum for all services (Network/Non-network)		
Hospice	20% Network/20% Non-network		
Home Health Care No RN/LPN unless billed through a Home Health Care Agency	20% Network/40% Non-network	20% Network/40% Non-network	$20 Copay per day Network/40% Non-network
	Private Duty Nursing limited to $5,000 plan maximum per enrollee		
Home IV Therapy	20% Network/40% Non-network	20% Network/40% Non-network	$20 Copay per day Network/40% Non-network
Employee Assistance Program	Provides consultation and referral services for personal concerns for employees and their household members.		
Managed Mental Health including Substance Abuse	Authorization of all inpatient and outpatient psychiatric and substance abuse services is required. If authorization is not obtained benefits will not be allowed.		
Covered Same As Any Other Condition	20% Network/40% Non-network	20% Network/40% Non-network	$500 Inpatient Copay Network/40% Non-network $20 Office Visit Copay Network/40% Non-network
	*THESE SERVICES MUST BE CERTIFIED BY CONTRACTOR TO RECEIVE BENEFITS.		
Lifetime Maximum Includes Human Organ and Tissue Transplants (HOTT)	$2 million Network and Non-network combined		
Human Organ and Tissue Transplants (HOTT) Specialty Network	20% Network/40% Non-network See contract for other maximums and exclusions	20% Network/40% Non-network See contract for other maximums and exclusions	$2,000 Network/40% Non-network See contract for other maximums and exclusions
Prescription Drug Options: Network Tier structure equals 1/2/3 (and 4, if applicable) Including Birth Control	Network / Non-network	Network / Non-network Combined $25 deductible for retail and mail order per person per calendar year.	Network / Non-network
	Tier 1 10% 40% Tier 2 20% 40% Tier 3 & 4 40% 40%	Tier 1 10% 40% Tier 2, 3 & 4 20% 40%	Tier 1 $10 40% Tier 2 $20 40% Tier 3 & 4 40% 40% (min.$40; max.$100)
	Tier 1 10% Not covered Tier 2 20% Tier 3 & 4 40% Not covered	Tier 1 10% Not covered Tier 2, 3 & 4 20% Not covered	Tier 1 $20 Not covered Tier 2 $40 Tier 3 & 4 40% Not covered (min.$80; max. $150)
	Network Retail Pharmacies: up to a 34-days supply of medication or 100 units Anthem Rx Direct Mail Service: up to a 90 day supply	The prescription drug copays do not apply to the medical out of pocket. Network Retail Pharmacies: up to a 34-days supply of medication or 100 units Anthem Rx Direct Mail Service: up to a 90 day supply	The prescription drug copays do not apply to the medical out of pocket. Network Retail Pharmacies: 100% of allowable cost after copayment up to a maximum of 34-days supply of medication or 100 units Anthem Rx Direct Mail Service: 100% of allowable cost after copayment up to a maximum 90 day supply
	The network penalty will be waived if there is no network pharmacy within 12 miles of the participant's home.		

	Now Called:	Previously known as:
Tier 1	Preferred Prescription Drugs	Generic
Tier 2	Preferred Prescription Drugs	Formulary Brand
Tier 3	Non-Preferred Prescription Drugs	Non-Formulary Brand
Tier 4	Prescription Drugs	Mostly injectable drugs

See Benefit Booklet for exclusions.

Notes:

- Dependent age: to end of the calendar year after the child's 19th birthday; or to the end of the calendar year after the child's 23rd birthday if the Dependent qualifies as a Full Time Student.
- No deductible carry over credit

This benefit description is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.